ACT-ing Faithfully: The Next Generation of ACT Fidelity Measurement

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Today's Presentation: An Overview

1. PACT implementation in WA: history & policy context
2. Why fidelity measurement is important
3. The DACTS: historical context & limitations
4. Overview of Washington State PACT Fidelity Scale
5. Highlights on enhancements to DACTS in new scale
6. Results from piloting new scale in WA & PA
7. Summary, conclusions, & next steps

What is ACT?

- An evidence-based practice (EBP) for adults with severe and persistent mental illness
- A team-based approach to providing treatment, rehabilitation, and support within the community
- Focus on working collaboratively with consumers to address full range of needs in the community:
  - ✓ Obtaining housing
  - ✓ Securing benefits
  - ✓ Engaging community
  - ✓ Improving skills
  - ✓ Working with families
  - ✓ Gaining employment

System Transformation Initiative

Washington State Department of Social & Health Services

PACT Implementation
NASMHPD Research Institute
2008 Conference

February 11, 2008

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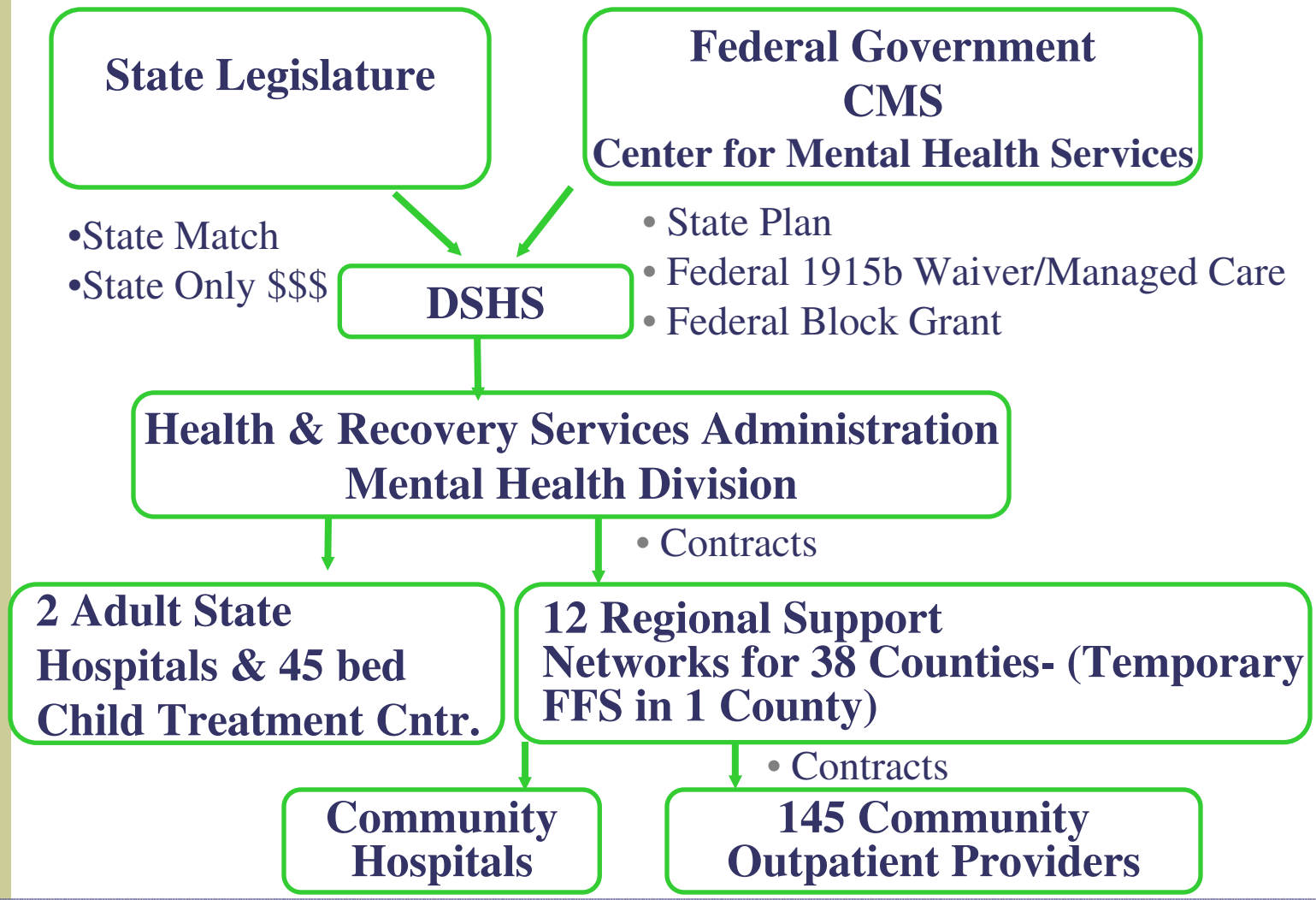
Washington State Mental Health System

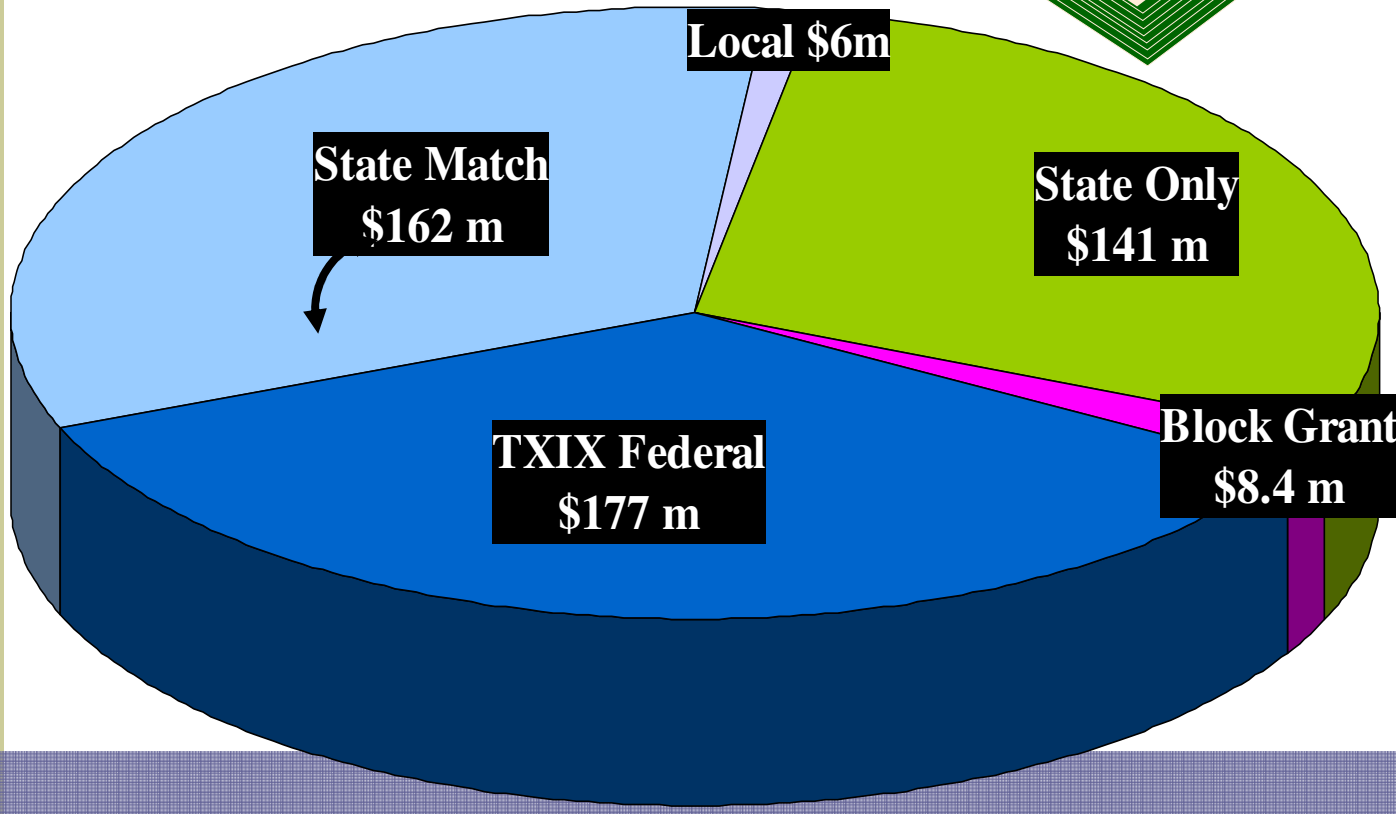
Mission

The Mental Health Division
Administers a
Public Mental Health System
that Promotes
Recovery and Safety

Washington MHD Structure



Washington Publicly Funded Community Mental Health System



Washington's State Hospitals Serve Small % of individuals but use 30% of $$$

- $246 m serves 3,500 people
- $494 m serves 122,000 people

Washington State Mental Health Statistics

Fiscal Year 2007 Statistics

- General Population- 6.4 million
- RSN Medicaid Eligible Covered Lives- 1 million
- People Served by Community Programs:
  - 121,837 total served in community outpatient
  - 95,000 (78%) are Medicaid eligible
- State Hospital Average Daily Census
  - Adult Civil Units- 919
  - Adult Forensic Units- 329
  - Child Study Treatment Center- 44
- RSN Community Inpatient Utilization
  - Approximately 346 inpatient community beds daily
  - 126,334 days in FY 07

Context for PACT Implementation in Washington State

Challenges Facing the 2006 Legislature

- Decreasing community psychiatric inpatient capacity
- State hospital waiting lists
- Court rulings in September 2005
  - No wait for transfer of 90/180 ITA patients
  - Failure to follow proper procedures for assessing "liquidated damages"
- Variable inpatient utilization and lengths of stay
  - Long lengths of stay in Washington's state hospitals
  - Significant disparities in lengths of stay when comparing state hospitals
  - Significant disparities between RSNs in per capita inpatient utilization

Context for PACT Implementation (cont'd)

DSHS Approach Incorporated in Budget and Legislative Initiatives

- Clarified roles of State & RSNs related to community and state hospital care
- Time limited investment in State Hospital capacity to deal with inpatient access issues
- Investment in enhanced community resources to reduce reliance on state hospitals
  - $10.4 million annually for PACT (State Funded)
  - $6.5 million annually for other alternatives
- Long term planning

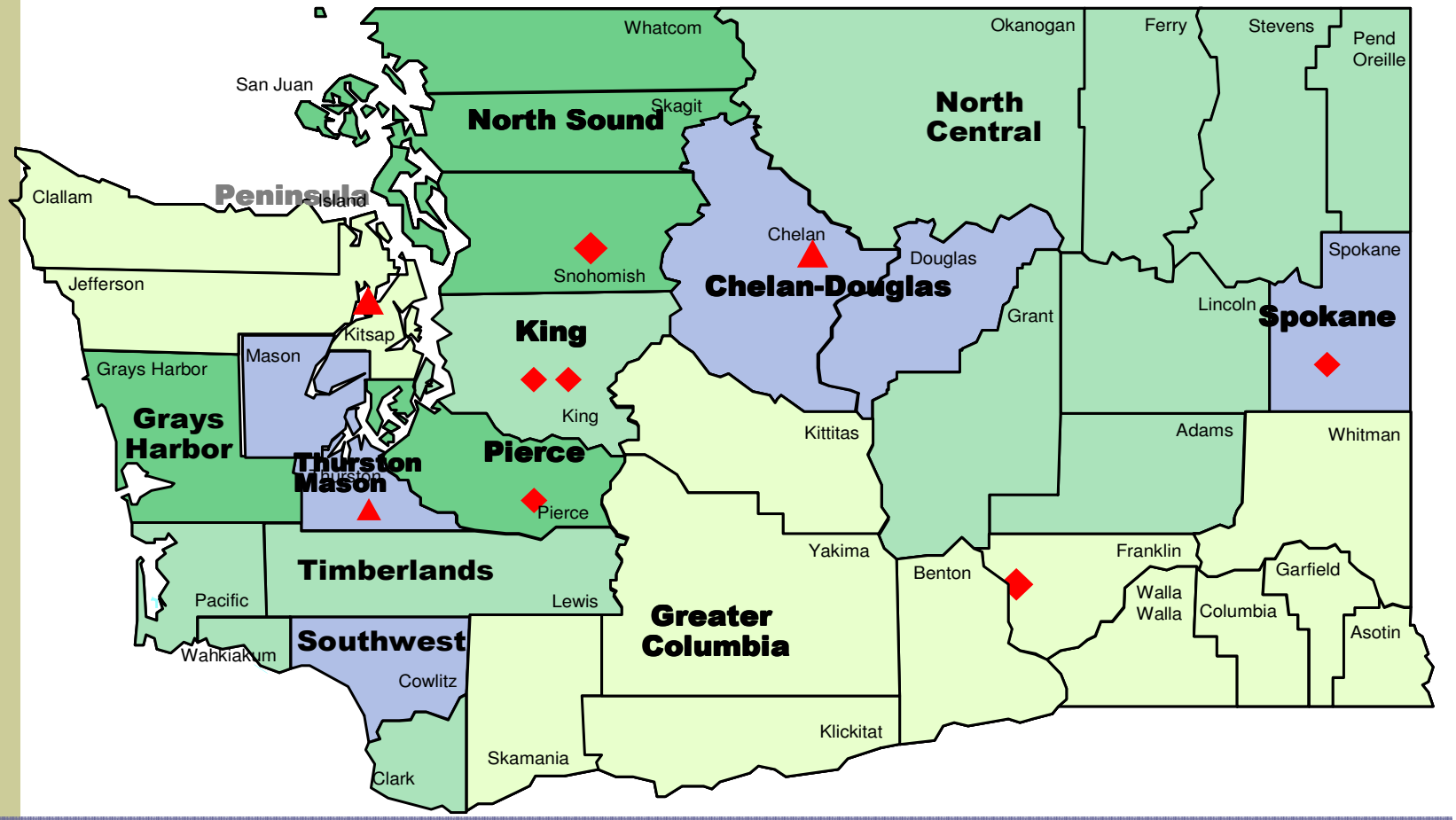
PACT Implementation

- 6 western PACT RSNs (7 teams) began serving consumers in July ’07
- 3 eastern PACT RSNs (3 teams) began serving consumers in October ’07
- Each PACT team is staggering consumer admissions (4-6 per month) until full capacity is reached
  - 205 consumers (total) have been enrolled as of mid December
  - Eventually will serve between 648 to 800 statewide
- State Hospital patients have priority for admission to PACT
  - Over half of the enrolled PACT consumers are from the State Hospitals
  - Gradual RSN bed allocation reductions (90 at WSH and 30 at ESH) associated with PACT between September 08 and October 09

Location of Washington Pact Teams

◆ = Full Team

▲ = Half Team



PACT Training & Consultation

- PACT teams shadowed high fidelity PACT teams in Tulsa, OK
- Individualized PACT Start-Up Training
- PACT Booster Training
- Burnout Prevention Training
- Training in Core Content Areas:
  - Motivational Interviewing & Dual Disorders Treatment
  - Supported Employment
  - Strengths-Based Assessment & Person-Centered Planning
  - Safety & Therapeutic Boundaries
  - Team Leader retreat & ongoing team role break-out sessions
- Ongoing program-level and clinical consultation

PACT Outcomes

- In addition to fidelity monitoring, MHD is gathering outcome data in the following areas and initial review and analysis of outcomes expected in December '08:
  - State Hospital utilization
  - Community inpatient utilization
  - Crisis service utilization
  - ER utilization
  - Housing
  - Employment
  - Arrests and incarceration
  - Substance Use

Background on WA-PACT Fidelity

- WA-PACT Program Standards include improvements to National Standards in Person-Centered Planning & Consumer Rights
- Policy & Procedure guidelines comporting with WA-PACT Standards created and disseminated to PACT teams
- Comprehensive website created to include PACT resources, updates on statewide implementation, training/TA
- The WA-PACT Fidelity Scale and Protocol- based on the Dartmouth Assertive Community Treatment Scale (DACTS)

"If it weren't for the compassion and services from the [PACT team] I would either be back at Western, strung-out on the streets, or dead."

- From an on-site fidelity review interview with a consumer who had been at Western State Hospital for nearly 10 years prior to being enrolled in PACT

Wrap Up

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http://www1.dshs.wa.gov/Mentalhealth/STI_Main.shtml

Fidelity Measurement in ACT

What is fidelity, why does it matter, how have we been addressing it with ACT, and what are the concerns?

Fidelity: The Term In Use

- The degree to which a program has been implemented as intended.
- The degree to which a program is a faithful replication of the ideal or benchmark model.
- The degree to which a program includes features that are critical to achieving the intended outcomes and excludes those that interfere with achieving those outcomes.

Fidelity Measures: Typical Purposes

- Practice, research & evaluation
  - Compare actual with intended intervention
  - Ensure replication and/or prevent drift
- Research & evaluation
  - Ensure validity of interpretation of results
  - Decompose to discover active ingredients
  - Measure strength in multi-site studies
  - Criteria for site inclusion/exclusion in multi-site studies

Fidelity Measures: Typical Steps In Development

- Determine critical elements
  - A small subset of total program features
- Define feasible indicator for each element and specify data source
- Define performance range
- Specify anchors on multi-point scale or ranges in associated measure
- Collect data in representative settings
- Evaluate measurement properties and revise as needed

Value of Model Fidelity

- Model fidelity is correlated positively with outcomes
  - Outcomes come too slowly to use exclusively as feedback
- Investing in what works is cost-effective
  - Builds on knowledge, avoids reinventing the wheel
  - Professional opinion can be flawed
  - This requires good science
- Provides a conceptual base for informed adaptation and innovation
  - Adaptation presupposes a sound conceptual base
  - Requires careful monitoring of program features and outcomes

Fidelity Measurement in ACT

- Substantial evidence of ACT effectiveness
  - Correlated positively with model fidelity
  - May be weaker more recently
    - Better services in comparison groups (model drift)
    - Environmental changes (funding & policies, client culture)
    - Lower fidelity in intervention groups (insufficient knowledge, innovator strength, popularization)
- Risks from limitations in model specification
  - Scientific: weak measures compromise scientific progress
  - Programmatic: suboptimal implementation leads to poorer outcomes

Fidelity Measurement Challenges

- Measurement is selective – trade-offs
- Measurement decisions are context-bound
  - Different contexts may invalidate initial assumptions
  - Contingencies may invalidate operational assumptions
- Elements of fidelity measure should ideally relate to program theory
  - Measure structures & processes (not outcomes)
  - Structure is typically easier to measure, but insufficient
  - Structures support processes, which yield outcomes
  - Determination of critical elements follows from theoretical as well as empirical bases for achieving outcomes

The Dartmouth Assertive Community Treatment Scale (DACTS): History

- No program manual available at the time
  - Used expert guidance, anecdotal history & evidence
- Initial development in a multi-site study of ACT for persons with co-occurring substance use disorders
  - Measurement needs specific to that study
  - Somewhat greater emphasis on substance abuse than other treatment & rehabilitation areas
- Incorporated assumptions about correlations among measured and unmeasured phenomena
- Some revision & testing with a larger set of studies and programs, not all ACT
- Program theory not well articulated at the time

Dartmouth ACT Scale
(Teague, et al., 1998)

- Program implementation / fidelity measure
  - 28 items
  - 5-point anchored scales
  - 3 groups of items (structure informed by McGrew et al., 1994)
    - Human Resources
    - Organizational Boundaries
    - Services
- Strong relationship between fidelity on the DACTS and outcome (McHugo, 1999)

Example: H1. SMALL CASELOAD

Domain	Rating				
	1	2	3	4	5
Small Caseload	50 clients per team member or more	35-49	21-34	11-20	10 clients per team member or fewer

Example:
O4. Responsibility for Crisis Services

Domain	Rating				
	1	2	3	4	5
Responsibility for Crisis Services	Not responsible for handling crises after hours	Emergency service has program-generated protocol	Program available by phone; consult role	Program provides emergency service backup	Program provides 24-hour coverage

DACTS: Current status

- Widely used for program guidance, verification of implementation, quality improvement, and effectiveness studies
- Sometimes used by regulatory authorities as one of various components in accreditation
- Incorporated into Evidence-Based Practices (Toolkit) Project
- Served as model for measuring fidelity of other EBPs for persons with serious mental illness
- Gaps and limitations have been identified as ACT has evolved and as use of DACTS has widened

DACTS: Concerns

- Incomplete coverage of potentially critical areas
  - Omitted areas ignored by some users
  - Original measure highly pragmatic & empirical, little direct grounding in program theory
  - Critical processes not measured; structures too easy
- Measurement gaps
  - Person-centered assessment & treatment/recovery planning
  - Team functioning
  - Staff roles
  - Specifications for included interventions
  - Recalibration of some items needed

Program Theory and Evidence-Based Practice: An Illustration

- Program Theory
  - A theory of action explicating the mechanisms through which a program will achieve its desired outcomes
- Who mends a broken bone?
  - The EBP: physician aligns and immobilizes broken parts
  - The patient helps to maintain these conditions
  - The parts knit together
- Inference
  - The practitioner uses proven technique in collaboration with the patient to establish the supportive conditions that allow the natural healing forces in the patient to operate

Alternative Program Theories

- A provider-centered theory
  - Outcomes result from practitioners' actions
  - Implicit or explicit shared belief in consumer's limitations
  - Emphasis on medication and stability
  - Often need to work against or around client's wishes
- A consumer-centered theory
  - Outcomes result from adaptive change in consumer
  - Practitioner and consumer collaborate in creating conditions to realize consumers' goals
  - Explicit belief in potential for recovery
  - Consumer develops, practitioner adapts

Complexity Science: Theoretical Framework for Recovery & ACT

- Features of complex adaptive systems (CAS)
  - **Agents:** interact locally with other agents & environment
  - **Co-evolution**: CAS evolve with environments that are continuously changing
  - **Emergence**: can't predict well from initial conditions
  - **Self-organization**: capacity to self-organize is partially a function of number and intensity of connections
- Narratives: ideal source for understanding CAS
- Implication: CAS applies to recovery and team
  - Roles & processes critical for high-fidelity implementation of ACT

The Washington State PACT Fidelity Scale

How did Washington State approach fidelity tool development, given known DACTS limitations?

Our Collaborators

- Building on the work of the ACT Center of Indiana:
  - Gary Bond, PhD
  - Michelle Salyers, PhD
  - Angela Rollins, PhD
- Core Content Development:
  - Natalie DeLuca, PhD, Fidelity Monitor, National EBP Project
  - Gary Morse, PhD, Lead Trainer, National EBP Project
  - Janis Tondora, PsyD, Yale Program for Recovery & Community Health
- Ongoing Vetting & Feedback:
  - ACT teams & experts nationally
  - Piloting fidelity reviewers in WA & PA
  - Interested & future pilot states

WA-PACT Fidelity Scale Development

- Applied DACTS template & general approach
  - Utility in an anchored scale vs. "is it there or not"
  - Much about the existing DACTS is useful
  - Many other states still use the DACTS
- Crosswalked WA-PACT Standards with DACTS
- Recalibrated some existing items
- Added items related to core processes
- Included more specificity within DACTS protocol
  - Formally added consumers as respondents
- Added data collection forms & checklists

H3b. Daily Organizational Staff Meeting (Quality)

H3b. Checklist	1	2	3	4	5
Reviews all consumers/previous day's contacts		x	x	x	x
Records status of all consumers			x	x	x
Schedule based on Weekly Consumer Schedules				x	x
Schedule based on emerging needs; problem resolutions are articulated or delegated				x	x
Scheduled contacts are proactive/focused on preventing future crises; staff share expertise in addressing issues					x
Staff are held accountable for follow-through					x

Initial Piloting of Enhanced Tool

- More inclusive straight out of the gate (50+ items)
- Two seasoned fidelity reviewers conducted baseline fidelity assessments with first WA-PACT team*
  - Baseline assessment for new teams
  - Training new WA fidelity assessors
  - Piloting of new tool
- Learned much from first 2 baseline assessments
- Piloted early version with 4 teams in PA
- All contributed to current beta version of scale

*** One reviewer returned for baseline assessment with second PACT team & continued training/piloting**

WA-PACT Fidelity Scale – *beta* Version

- 48 items; 5-point anchored scales
  - Many of same anchors & items from DACTS
  - Enhancements & additions as described
- 4 subscales:
  - Human Resources
  - Organizational Boundaries
  - Services
  - Person-Centered Recovery-Oriented Approach
    - All new items (5)

General Approach to Remaining Reviews

- Review in pairs; independent ratings & consensus on final team rating
- Currently takes two days per fidelity review
- Primary data sources:
  - Observation of daily team meeting, treatment planning meeting, community visits
  - Chart review (random selection of 10)
  - Interviews with all staff
  - Interviews with consumers (3-5)
- Use enhanced protocol & data collection forms
- Feedback report/meeting: performance improvement

Highlights on Enhancements to the DACTS

What did we change & why?

Summary of Scale Enhancements

- Differentiated standards for full and half teams
- Clearly defined role expectations and emphasized team functioning
  - Overall greater emphasis on general and specific clinical processes
- Reduced subjectivity of item anchors and unbundled multiple-barreled items
- Recalibrated item anchors to better reflect best practices
- Removed items not judged to be critical to the model and added items now viewed as key elements of high fidelity

Different Standards for Full and Half Teams

	High ACT Fidelity Standard	
	Full Team	Half Team
Low Ratio of Consumers to Staff	10:1	8:1
Team Approach Percent of consumers who have face-to-face contact with at least 3 staff in 2-week period	90%	58%
Program Size Number of direct clinical staff	10 FTE	7 FTE
Community-Based Services Percent of face-to-face contacts that are in the community	85%	75%

Full Teams are defined as 100 consumer caseload.
Half Teams are defined as 50 consumer caseload.

Clearly Defined Role Expectations

- Role in providing treatment to consumers
  - More comprehensive survey of core practices
  - Emphasis on delivering other EBPs
- Role within treatment team
  - Modeling skills and individual consultation
  - Cross-training
  - Attend daily organizational team meeting
  - Attend treatment planning meetings

Role of Vocational Specialist

In treatment

Provides supported employment services.

Core services include:

- Engagement
- Vocational assessment
- Job development
- Job placement
- Job coaching and follow-along supports

Within team

- Models skills and provides consultation
- Cross-trains staff in supported employment
- Attends all daily organizational team meetings
- Attends all treatment planning meetings for consumers with employment goals

Eliminations and Additions

Eliminations

- Continuity of staffing
- Staff capacity

Additions

- Office-based program coordinator
- Supported employment model
- Person-Centered, Recovery-Orientation Approach
  - 5 items

R3. Person-Centered Planning

- Development of formative treatment plan ideas based on initial inquiry and discussion with the consumer (prior to the meeting)
- Conducting regularly scheduled individual treatment team (ITT) treatment planning meetings
- Attendance by staff from the ITT, the consumer, and anyone else consumer prefers (e.g., family, significant others)
- The planning meeting is driven by the consumer's goals and preferences
- Provision of coaching and support to promote self-direction and leadership within the meeting.

Modification of Anchor Distribution and Standards for High Fidelity

Examples of Items where the Standard for High Fidelity was Adjusted

Item	DACTS	WA-PACT
Team approach-- ≥ 90% consumers have face-to-face contact with	at least 2 staff members in two weeks	at least 3 staff members in two weeks
Nursing staff	≥ 2 FTE in 100 consumer program	≥ 3 FTE in 100 consumer program
Frequency of contact	Average of ≥ 4 face-to-face contacts/week per consumer	Average of ≥ 3 face-to-face contacts/week per consumer

Daily Team Meeting

- DACTS' Program Meeting item
  - Frequency of meeting and whether all consumers were reviewed
- H3a. Daily Organizational Staff Meeting (Frequency and Attendance)
- H3b. Daily Organizational Staff Meeting (Quality)
  - Reviews all consumers
  - Records all previous day's contacts
  - Creates schedule based on weekly consumer schedules, emerging needs, & the need for proactive contacts to prevent future crises
  - Staff are held accountable

Recruitment and Referral

- DACTS' Explicit Admission Criteria Item
  - Double-barreled and subjective
- O1b. Recruitment and Referral (Explicit Admission Criteria)
  - At least 90% of caseload meet specific admission criteria
    - Diagnosis
    - Functional impairment
    - Continuous high service needs
- O1c. Recruitment and Referral (Active Recruitment)
  - Regular screening and planning for new admissions
  - Outreach to common referral sources (e.g., hospitals, jails, shelters)

Responsibility for Service

- DACTS' Full Responsibility for Treatment item
  - Whether team directly provides 5 services
    - Little guidance in determining whether a service is actually provided or brokered
    - Too much packed into one item
- Separated into 6 individual items
  - Case management
  - Psychiatric services
  - Substance abuse treatment
  - Employment services
  - Rehabilitation services
  - Wellness management and recovery

Responsibility for Service

- The percent of consumers who are receiving a needed service (including engagement around service) and the extent to which the PACT team is assuming responsibility for delivering this service
- Some brokering is appropriate given consumer choice
- Consumer choice is not reasonable if driven by team's limitations or convenience
  - Formula:

$$\frac{\%\text{ receiving service from team} + \textit{reasonable}\ \%\text{ receiving services externally}}{\%\text{ needing and/or wanting service}}$$

Open-Ended Services/Graduation

- DACTS' Time-Unlimited Services (Graduation Rate)
  - All consumers are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
- Revised measurement of construct to recognize the value of graduation as a goal and incorporate recommended step-down processes
  - Regular assessment of need using explicit criteria
  - Individualized gradual transition as indicated to less intensive setting with monitoring & option to return to team.

Pilot Fidelity Scale, Methods & Results

Overview of enhanced measure, assessment process, questions & findings

WA-PACT Fidelity Scale

- 48 items
- 5-point anchored scales
- Detailed scoring protocol
- Items reorganized into different groups
  - New and changed items suggested modified logic
- Alternative structure
  - Structure & Organization (11)
  - Staffing & Roles (16)
  - Services (17)
  - Recovery Practices (4)

Structure & Organization
(Current Items)

- Low ratio of consumers to staff
- Team approach
- Daily organizational staff meeting (frequency & attendance)
- Daily organizational staff meeting (quality)
- Program size
- Recruitment & referral (explicit admission criteria)
- Recruitment & referral (active recruitment)
- Gradual admission rate
- Open-ended services/graduation
- No dropout policy
- Active stakeholder advisory group

(black = similar to DACTS)
(green = greatly modified)
(blue = new item)

Staffing & Roles (Current Items)

- Team leader on staff
- Team leader role
- Office-based program coordinator on staff
- Psychiatric prescriber on staff
- Psychiatric prescriber's role (in treatment)
- Psychiatric prescriber's role (within team)
- Nurses on staff
- Role of nurse
- Chemical dependency specialist on staff
- Role of chemical dependency specialist (in treatment)
- Role of chemical dependency specialist (within team)
- Vocational specialist on staff
- Role of vocational specialist (employment services)
- Role of vocational specialist (within team)
- Peer specialist on staff
- Role of peer specialist

Services (Current Items)

- Full responsibility for case management services
- Full respons. for psych. scvs.
- Full respons. for SA treatment
- Full responsibility for employment services
- Full responsibility for rehab. services
- Full responsibility for wellness management services
- Responsibility for crisis services
- Responsibility for hosp. adm.
- Responsibility for hospital d/c planning
- Community-based services
- Assertive engagement
- Intensity of service
- Frequency of contact
- Frequency of contact with natural supports
- Individual and group dual disorders treatment
- Dual disorders (DD) model
- Supported employment (SE) model

Recovery Practices (Current Items)

- Strengths inform treatment plan
- Person-centered planning
- Interventions target a broad range of life goals
- Consumer self-determination and independence

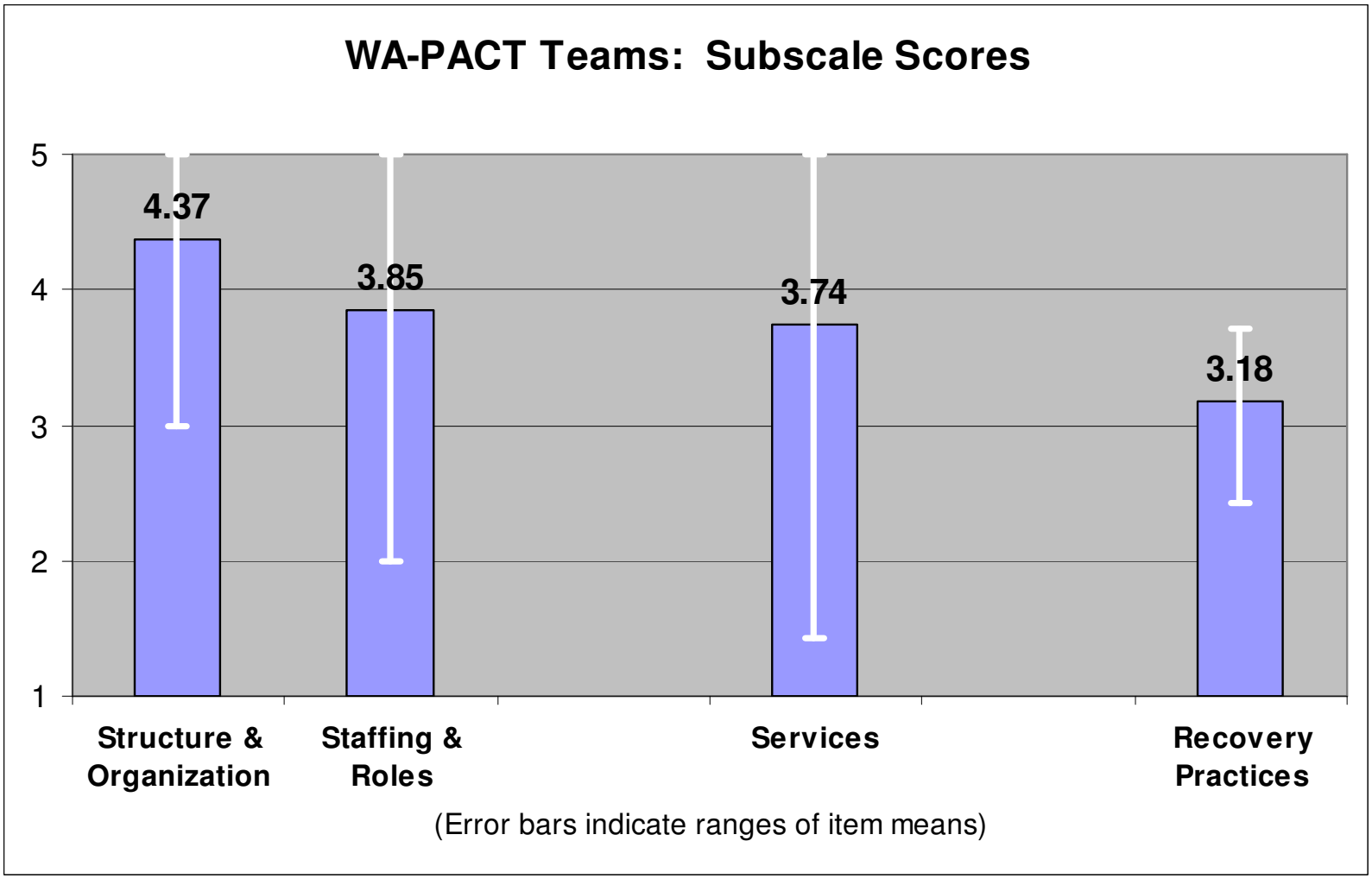
Methods

- Conducted fidelity assessments with 11 ACT teams:
  - WA: 7 ACT teams at 4-5 months post-implementation (baseline)
  - PA: 3 mature teams (6 yrs) and 1 team at 1 year post-implementation
- WA-PACT utilized two reviewers; PA used one
- PA used earlier version of pilot tool
  - Different O3 items & new item on Consumer Self-Determination (R8)
- PA & WA used similar protocol & data collection forms

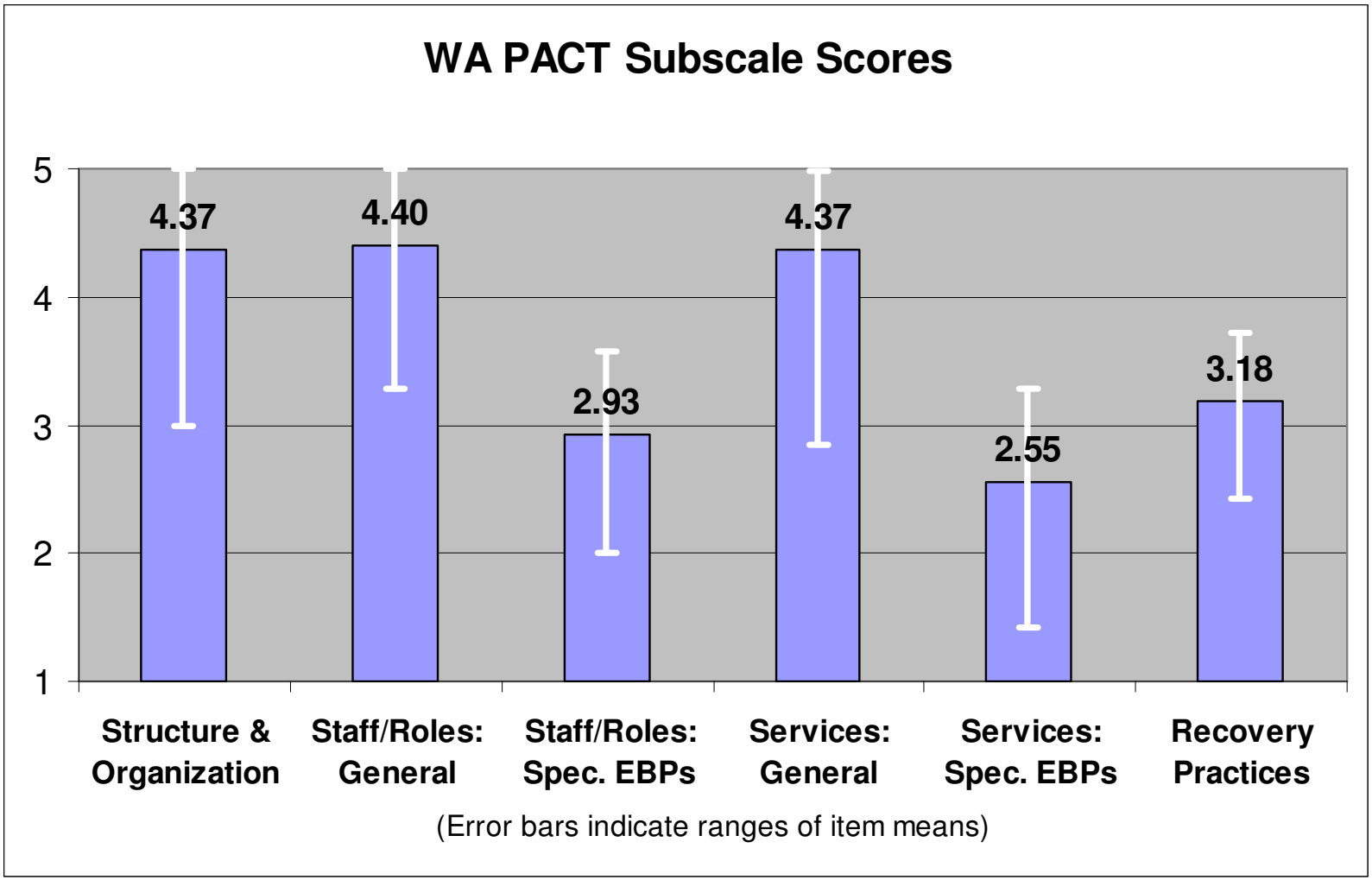
Questions

- How are WA teams doing early in their implementation?
  - WA-PACT as a whole
  - Areas needing additional training & development
  - Differences among teams
- How do young WA teams look relative to mature teams elsewhere?
- How do results on the enhanced measure compare with results using the existing DACTS?

WA-PACT Teams: Subscale Scores



WA-PACT Teams: Subscale Scores



Structure & Organization: Item Scores

Low ratio of consumers to staff	5.00
Recruitment & referral (explicit admiss. criteria)	4.86
Gradual admission rate	4.86
No dropout policy	4.86
Program size	4.71
Team approach	4.71
Daily organizational meeting (freq. & attendance)	4.14
Active stakeholder advisory group	4.14
Daily organizational staff meeting (quality)	3.43
Recruitment & referral (active recruitment)	3.00

Staffing & Roles: Selected Item Scores (General Items)

Team leader on staff	5.00
Peer specialist on staff	5.00
Psychiatric prescriber on staff	4.86
Nurses on staff	4.86
Psychiatric prescriber's role (in treatment)	4.71
Role of nurse	4.43
Psychiatric prescriber's role (within team)	4.14
Office-based program coordinator on staff	4.00
Role of peer specialist	3.71
Team leader role	3.29

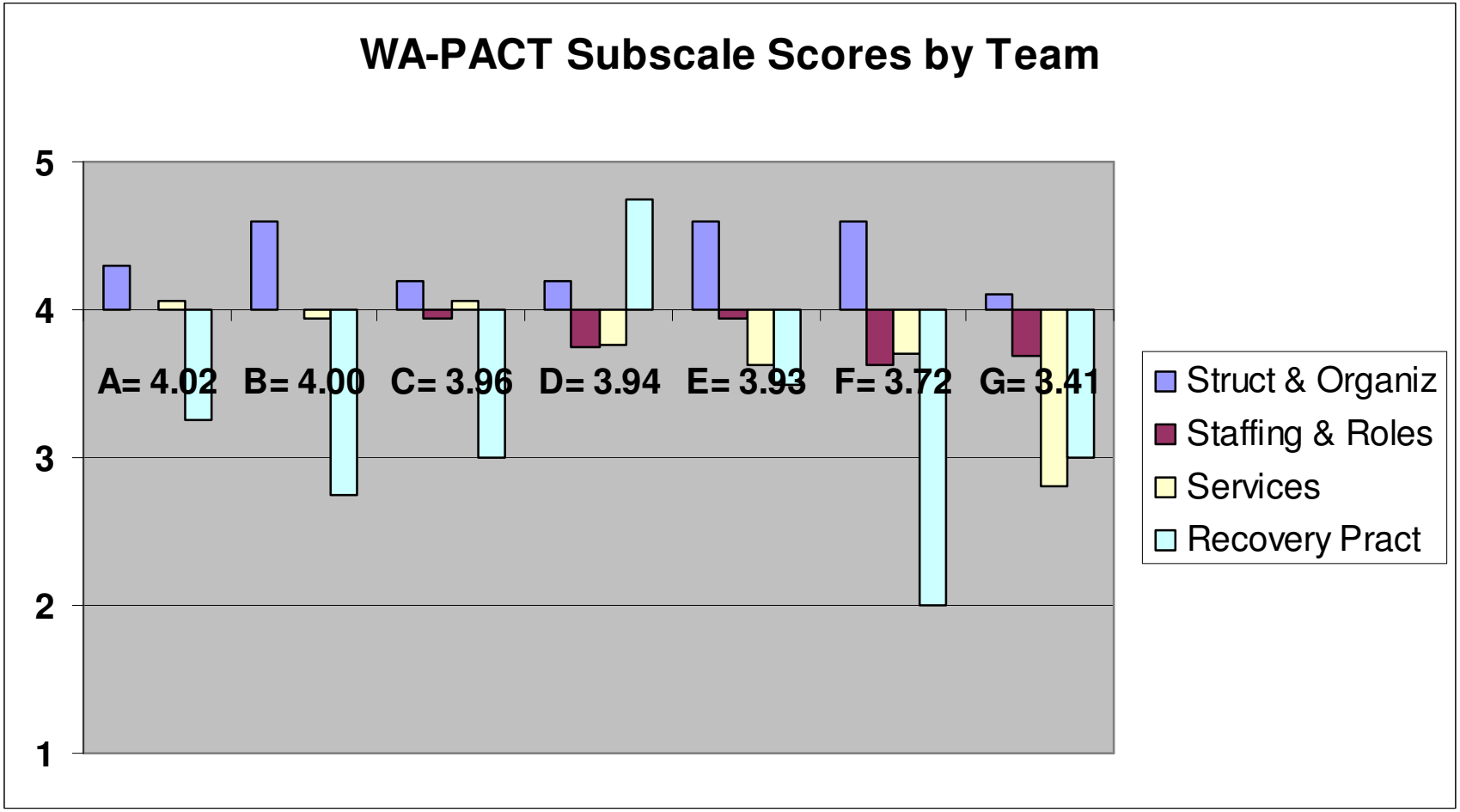
Services: Selected Item Scores
(General Items)

Community-based services	5.00
Intensity of service	5.00
Frequency of contact	5.00
Responsibility for hospital discharge planning	4.67
Responsibility for hospital admissions	4.60
Full responsibility for rehabilitative services	4.57
Responsibility for crisis services	4.57
Full responsibility for case management services	4.43
Full responsibility for psychiatric services	4.43
Assertive engagement	3.14
Frequency of contact with natural supports	2.86

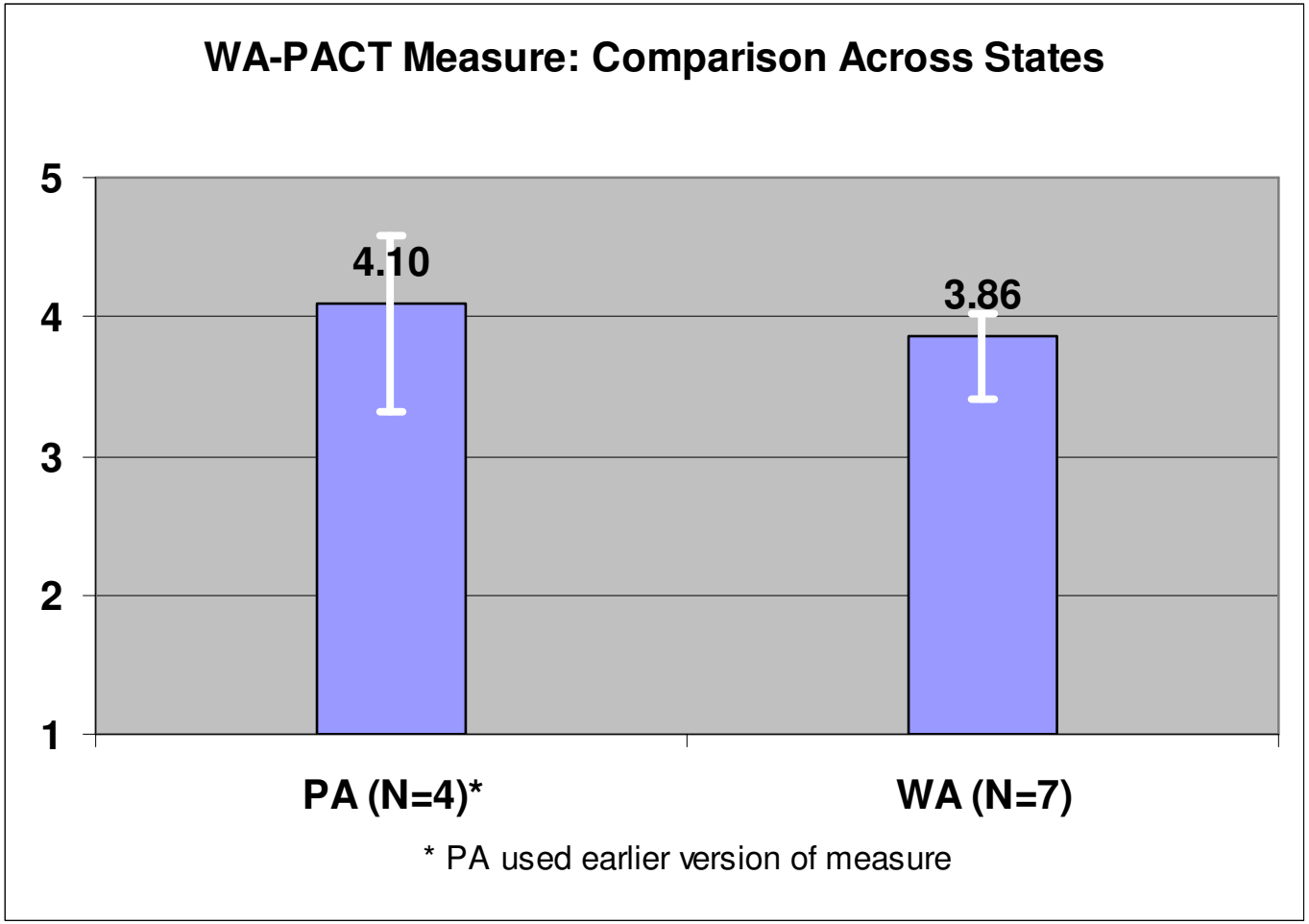
Recovery Practices: Item Scores

Consumer self-determination and independence	3.71
Person-centered planning	3.57
Interventions target a broad range of life goals	3.00
Strengths inform treatment plan	2.43

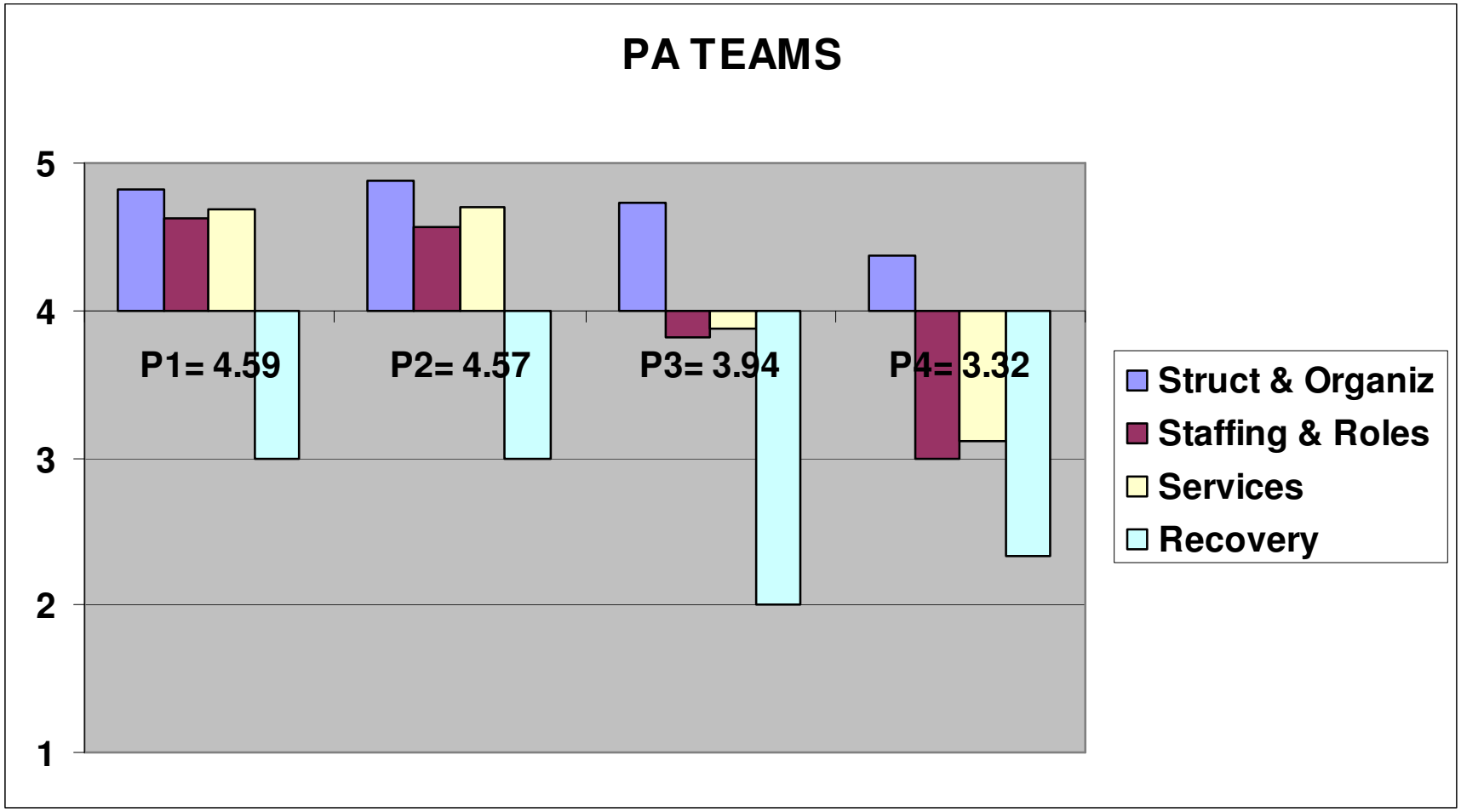
WA-PACT Subscale Scores by Team



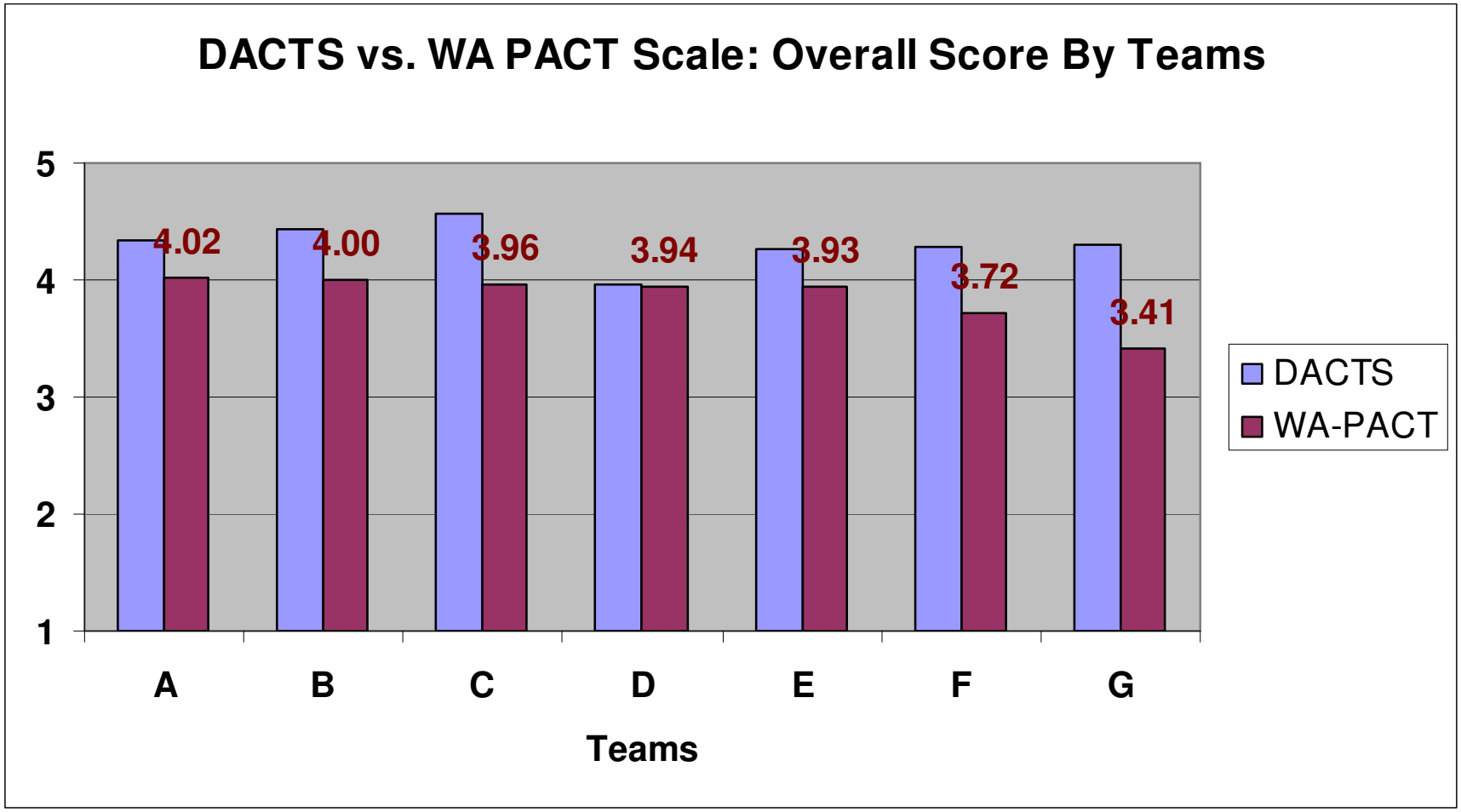
Comparison with Teams in Another State



PA Teams: Subscale Scores



Comparison with the DACTS



Discussion, Conclusions & Next Steps

Where do we go from here?

Inferences About WA-PACT Baseline Fidelity: Strengths

- Preliminary baseline fidelity scores
  - WA-PACT = range 3.4 – 4.0
  - DACTS = range 3.9 – 4.6
- ACT is in place; looks like ACT
  - Community-based
  - Team-based
  - Small staff-to-client ratio
  - Mainly admitting intended group of consumers
  - Most staffing is in place; meet qualifications
- Early evidence of person-centered, recovery-oriented practices

Inferences About WA-PACT Baseline Fidelity: Challenges

- In crisis mode rather than proactive and sustainable interventions. Evidence:
  - Quality of daily team meeting
  - Treatment planning process
  - Documentation observed in chart review
- Person-centered approaches are evolving
- Specialists tend to be generalists
- Early understanding & incorporation of other EBPs
  - Integrated Dual Disorder Treatment
  - Supported Employment
  - Wellness Management Strategies

Process Evaluation: Most Useful Aspects of Fidelity Process

- Fidelity orientation for all WA-PACT teams was helpful in setting the stage for assessors
- "Useful" to "very useful" ratings on various types of data collection forms
  - Clustering content area vs. item order helps with flow of interviews & observations
- Checklists helpful in examining differences among possible ratings
- Obtaining program data ahead of review helpful for guiding follow-up questions at review; head-start

Process Evaluation: Challenging Items & Approaches

- Lots of feedback re: need for more specificity in protocol & data collection forms
- Full Responsibility for Services items (O3 a-g) is better unbundled, but can be difficult to assess
- New "Active Recruitment" item (O1c) – what constitutes referral from "outside agency"?
- Two of the recovery items (R2 & R4) are heavily reliant on good chart documentation esp. in tx plans
- Some difficulty with assessing whether contacts assessed in daily team meeting were "proactive"

Enhanced Measure: Summary & Conclusions

- WA-PACT Scale builds on existing standard (DACTS) & provides relevant enhancements
- Overall scale now includes wider range of theoretically critical elements
- Scale and protocol have sufficient demonstrated feasibility; additional refinements are planned
- Evidence for utility of scale in enhanced form
  - Better alignment with PACT standards
  - Shows sensitivity to aspects of team performance that may require additional development

Next Steps in Measure Development

- Continue piloting in WA to finalize scale (6 month reviews May-June 2008)
- Continue piloting in other states
- Fine-tune instrument & protocol
  - Incorporate assessors' experience
  - Decide re: retention, modification of items, anchors
  - Is there room for any additional items?
- Determine value added
  - Relative to leaner DACTS
  - Include in studies to assess relationship to outcome
  - Continue to evaluate benefit/cost question

Next Steps in Measure Application

- Examine whether WA-PACT Standards could be adjusted post-implementation
  - Implications for a “national model” reflected in such a tool
- Evaluate role of this measure in context of interest in brief measures for routine use
- Articulate training & utilization plan
  - Fixed vs. random selection of subset of items
  - Evaluate feasibility of web-based support

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